



Washington State Health Report

Washington State
Board of Health



WASHINGTON STATE
Board *of* Health

ALWAYS WORKING FOR A SAFER AND HEALTHIER WASHINGTON

CHRISTINE O. GREGOIRE
Governor



STATE OF WASHINGTON
OFFICE OF THE GOVERNOR

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August 11, 2006

Washington State Board of Health
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Dear Board Members:

I am pleased to return the *2006 Washington State Health Report* to you with my approval.

Every even-numbered year, the state Board of Health is required by RCW 43.20.50(1)(b) to prepare a report outlining health priorities for the ensuing biennium. The statute authorizes me to approve, modify, or disapprove this document.

Your report clearly articulates key challenges in making Washington safer and healthier for all residents. It also offers several strategies that correspond well with my own health policy goals, which include: (1) creating a sustainable, affordable, quality system; (2) improving the health of Washingtonians; (3) increasing access to health care coverage; and (4) improving the accountability of health care professionals.

I appreciate your efforts to work collaboratively with other agencies and the public. The *2006 Washington State Health Report* provides a superb foundation on which to build discussions for the next biennium. Thank you for your great work.

Sincerely,

Christine O. Gregoire
Governor



2006 State Health Report

Washington State Board of Health

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For persons with disabilities, this document is available on request in other formats. To submit a request, please call 360 236-4100.

Introduction

Since 1990, the State Board of Health has been responsible for producing a biennial State Health Report “that outlines the health priorities of the ensuing biennium.” RCW 43.20.50 requires that the report must be produced in even-numbered years and that the Governor must approve, modify, or disapprove the report. State health reports are intended to be tools state agency administrators can use as guides for preparing agency budgets for an upcoming biennium and for developing legislation to propose to the Legislature. The 2006 State Health Report is meant to be used during the summer and fall of 2006 to develop budget proposals for the 2007-09 biennium and legislation that agencies would like the 2007 Legislature to consider.

Over the years, these reports have changed somewhat in length, format, and content. The types of input considered also have varied. The public has always been consulted. The Board is required to hold forums across the state every five years. In the past, it scheduled the forums before drafting the report. This year, it decided to try something new—preparing a discussion draft of the report first and then asking for comments on the draft at the public meetings. The Board held three forums in the spring, one in Spokane, one in the Tri-Cities area, and one in King County. A few of the comments from participants are reflected in this essay, and we have added a new section of this report called “the public speaks” (see page 30). We have also added two essays that were not part of the discussion draft—one on mental health and one on veterans’ access to federally funded health care.

The Board has typically used polls, surveys, and other tools to gather additional input. It also consults with policy makers and experts in public health and medical care. In 2001, it began specifically to solicit suggestions from members of local boards of health, many of whom are elected local officials. And of course, the Board considers the best available scientific data and research findings.

The Board is also required to solicit ideas from the other agencies involved in health issues. In recent years it has gone beyond consultation, trying to be as collaborative as possible—and this year is no exception. When Governor Christine Gregoire took office in 2005, she immediately declared her three health policy goals—contain costs and improve quality, cover all children by 2010, and make Washington the healthiest state in the nation. She then convened interagency workgroups to develop specific policy initiatives in each of these areas. In this report, the Board has invited heads of other agencies to describe health priorities in their own words. In particular, the executives of the three agencies that the Governor asked to lead the interagency workgroups that have been developing specific policy proposals will describe each of the Governor’s initiatives.

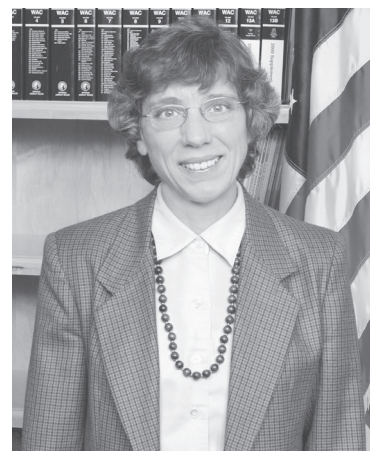
It is important to understand what this report is not. It is not meant to describe the state of health in Washington—the diseases and injuries we suffer, the causes of death, our health trends, or how Washington compares to other states. That kind of information is available in other documents: The Department of Health produces a report called *The Health of Washington State* that looks at our health status, factors that might threaten our health, and the availability of health services (www.doh.wa.gov/hws). A group of state and local agencies, the Public Health Improvement Partnership, has developed a *Report Card on Health in Washington* (www.doh.wa.gov/phip/reportcard). The Washington Health Foundation is also developing a *2006 Report Card on Washington’s Health* as part of its Healthiest State in the Nation campaign (www.whf.org/hsein/Outcomes.aspx). Local health departments also provide reports about the health of their communities.

Nor is this report designed to inventory all the things that agencies are currently doing—since there are too many to capture in one document and this report is required to look toward the future. Similarly, it is not meant to capture all the things agencies could or should be doing in the next few years to improve the health of Washingtonians. That information can be obtained from agency strategic plans and other documents. Instead, this report highlights strategic directions—high-level policy initiatives that deserve the attention of the Governor, the Board, and senior managers across state agencies.

State health reports are intended to be tools state agency administrators can use as guides for preparing agency budgets for an upcoming biennium and for developing legislation to propose to the Legislature.

Health: A Top Priority for Washington State

By Kim Marie Thorburn, Chair, State Board of Health



The Washington State Board of Health has attempted to be increasingly selective about what it includes in its state health reports, focusing in each time on a limited number of strategic directions. In recent years, these strategic directions have tended to be very similar—they have addressed, in one way or another, the capacity of the public health system, the cost and quality of medical care, health disparities, access to appropriate health services, healthy behaviors, and the environment. This year is no different, and in this essay I will lay out the Board's strategic directions for health care in the state of Washington.

Before I begin, though, I want to mention how exciting it is to have a Governor who is making health care a priority, Governor Christine Gregoire has been clear about her health care priorities since taking office in 2005—contain costs and improve quality, cover all children by 2010, and make Washington the healthiest state in the nation. Interagency workgroups have been working hard to develop specific policy initiatives in each of these areas. As those initiatives have developed, it has become increasingly clear that the Governor's three health priorities correspond nicely with the six strategic directions proposed by the Board.

Improve public health system capacity

Whether by preparing against the potential for a form of avian influenza virus that spreads readily among humans, keeping food and drinking water safe, teaching kids to avoid tobacco, or myriad other activities, public health is always working for a safer and healthier Washington. The people of this state expect and deserve a public health system that responds. Yet even with an infusion of federal and state resources to enhance public health emergency preparedness, funding and staffing for most local public health agencies in Washington have eroded over the past decade.

The state's public health system is better prepared for an emergency since the East Coast anthrax outbreak in 2001. Agencies have strengthened partnerships with departments of emergency management, improved disease surveillance and risk communication capabilities, and practiced emergency plans. There remains room for improvement, but progress has been made.

At the same time, a rising rate of obesity puts more of our population at risk for a variety of chronic diseases. HIV and other sexually transmitted disease infections occur at an alarming rate. Injuries continue to be a major cause of death and long-term disability in the young and old. Too many women, especially those with challenges like chemical dependency and family violence, do not receive adequate prenatal care to ensure a healthy start for their infants. A stronger public health system could reverse these trends, and participants at the public forums said they expect the system to do just that.

The progress that we have witnessed on diminishing tobacco use is a public health success story. Fewer young people are smoking and adult users are quitting. A well-resourced, multi-pronged program, including public awareness campaigns, cessation treatment, community- and

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school-based programs, and evaluation, is responsible for this health improvement. Tobacco prevention and control is an example of what the public health system can accomplish when capacity is adequate.

The Joint Legislative Select Committee on Public Health Financing created during the 2005 session is studying public health system capacity and will report its findings to the Legislature later in 2006.

Governor Gregoire's Healthy Washington initiative (see page 12) depends on a robust public health system. Access to quality health services is important to caring for sick and injured people, but dealing with the broad determinants of health—socioeconomic status, the environment, and behaviors—is needed to prevent disease and injury and to promote health.

Great advances in the health of the population come through disease and injury prevention activities such as immunizations, sanitation, and vehicle occupant restraints. Impacting the broad health determinants is the work of the public health system.

Improve health by promoting healthy behaviors

Healthy behaviors contribute to healthy lives. Chronic diseases and injuries rank among the principle causes of injury, illness, and death (morbidity and mortality) today in Washington. Much of the morbidity and mortality could be prevented or postponed with good nutrition, adequate physical activity, attention to safety, avoidance of harmful substances, and safe sexual behaviors.

Individuals are responsible for their behaviors, but careful choices are reinforced by strong policy, a supportive environment, and good information. The reverse can be seen when these elements are lacking. Poor nutrition caused by reliance on fast and pre-prepared foods along with physical inactivity related to our dependence on automobile travel have contributed to an epidemic of obesity, which increases the risk of several chronic diseases and injuries. Participants at the public forums repeatedly expressed concerns about poor nutrition and the need for health care providers to do a better job of identifying and addressing their patients' weight problems.

Again, tobacco prevention and control provides a model for success. After years of increasing smoking rates encouraged by glamour messages from Big Tobacco, the trend is finally reversing. Smoking rates in Washington are among the lowest in the nation. A well-funded counterattack, consisting of counter-advertising, policy and resource support for smoking cessation, school- and community-based programs, and improved environmental tobacco smoke policy, has brought down smoking rates (see chart, page 14) along with smoking-related diseases.

Other advancements have been seen in injury prevention through the requirement of seat belts, child passenger restraints, and helmets. Policy approaches to advancing healthy behaviors are often controversial. Gun control is a good example, as are science-based sex education and condom distribution. Well-formulated observational and research studies are important to providing a strong scientific basis for our policy choices.

Healthful behaviors begin early in life when they are encouraged by families, schools, and communities. Governor Gregoire's Healthy Washington initiative is exploring school-based programs that have worked to promote healthy behaviors in kids (see sidebars, page 16).

School districts that have traded fattening snacks in vending machines for healthier choices have shown that children will change their eating habits. New approaches to health and physical education are reengaging youth to be more active. Support for these activities may lead to lifelong healthy nutrition and physical activity behaviors.

Assure environments that promote and protect human health

Environmental health and protection efforts conducted by local governments, the state Department of Ecology, and other agencies do more than protect natural ecosystems, create recreational opportunities, promote tourism, and improve the quality of life. To the extent that polluted air, water, and soil, as well as contaminated food, have an adverse impact on human health, environmental health and protection can improve the health of the people of Washington. That is why environmental agencies and public health agencies are often critical partners that have overlapping goals and programs.

Toxic air pollutants can lead to birth defects, cancer, and other forms of illness. Millions of pounds of toxic pollutants enter Washington's air each year, primarily from diesel exhaust fumes, gasoline vapors, and wood smoke. The Puget Sound Clean Air Agency has estimated that 700 cancer cases a year in Washington are attributable to airborne toxins. Small airborne particles, particularly those less than 2.5 microns across, contribute to asthma and other lung diseases, sudden infant death syndrome, heart disease, and cancer. The Harvard Six Cities study followed 8,000 people for 16 years and found a 26 percent increase in death rates for people living in areas with elevated levels of particulates in the air.

Contaminants are also found in our water. Some, like mercury, persist in the environment for many years and accumulate in the food supply. Mercury contamination is associated with nervous system disorders, reproductive problems, learning difficulties, and developmental damage.

Our physical environment can also influence our behaviors in ways that affect our health. If we do not have ready and affordable access to trails, parks, and other recreational facilities, for example, we are less apt to be physically active—and inactivity contributes to our epidemic of obesity.

As Mary Selecky discusses in her essay on page 12, the Governor's Healthy Washington group is working with stakeholders to address environmental contaminants in places where children congregate. For a variety of reasons, children suffer more from exposure to environmental toxins than adults. The group is also supporting the Department of Ecology's efforts, in collaboration with the Department of Health, to reduce the number of "persistent, bioaccumulative toxins," such as mercury, that enter our environment. On page 18, Ecology Director Jay Manning explains what is meant by persistent, bioaccumulative toxins and discusses the state's approach to decreasing the harm they do to the environment and human health.

The Board and the Department of Health are currently working on a new set of rules to help ensure that schools are safer environments for children. Many people who attended the Board's forums emphasized the need to ensure that children are adequately protected from environmental hazards when they attend school. In addition, the Board and its partners will be working to encourage better communication between urban planners, architects, and local health officials to assure that the physical environments we build support healthy lifestyles.

Reduce health disparities

Health disparities are measurable differences in health outcomes experienced by different populations. Unequal distribution of social, economic, and political resources and structures among populations creates inequities and disadvantages for some groups.

The inequities result in poor access to societal benefits, increased exposure to risks, and innate predisposing conditions, which underlie health disparities.

Population differences among which we see health disparities include gender, age, race or ethnicity, education, income, language, disability, geographic location, and sexual orientation. Reducing health disparities would require more than improving access to health care since disparities arise from social, economic, and political inequities. Broad health determinants, such as educational attainment, employment, income, lifestyle behaviors, discrimination, and environmental conditions, can all contribute to health disparities. These factors must be identified and addressed.

Katrina and other natural disasters during 2005 were reminders of the impact of health disparities. People in poverty and people of color suffered disproportionately. Contributing to their suffering were issues such as inability to evacuate due to lack of transportation, substandard housing, a greater burden of chronic diseases and disability, or risk of exposure to violence.

Health disparities equate to earlier death, greater disease and injury burden, decreased quality of life, loss of economic opportunity, and a sense of injustice for affected populations. Society also suffers from less productivity, higher health care costs, and social inequity. Health disparities can be recognized by such examples as higher tobacco smoking rates and poorer nutrition among less educated Washingtonians, or more use of chewing tobacco among rural men. Higher rates of vaccine-preventable diseases and HIV infection occur among certain racial groups. Birth outcomes also vary by race.

It is the role of the public health system to serve as a convener to carry out the work of reducing health disparities. Impacted populations must be at the table to guide culturally sensitive approaches. Partnerships and coalitions are needed to tackle the broad determinants related to specific health issues. In the sidebar on page 8, Ellen Abellera, executive director of the Commission on Asian Pacific American Affairs, explains how state government has begun the process of involving communities and stimulating partnerships to address disparities.

The 2006 Legislature passed and the Governor signed a package of four bills designed to implement recommendations from the Joint Select Committee on Health Disparities. One new law created the Governor's Interagency Council on Health Disparities, staffed by the Board and tasked to develop a statewide plan for reducing health disparities by 2012. One of the Council's functions will be to evaluate proposed budget and policy changes, upon request, to determine their potential impact on efforts to end health disparities. The Department of Health will support the Council's efforts by collecting data on the health care workforce that could be used to identify underrepresented groups of people. Along with the state's educational institutions, the Department will assure training of health care providers to aid better understanding and responses to the needs of people from different cultures. Effectively implementing these new initiatives will be a challenge for both agencies over the next biennium.

The work to eliminate health disparities should not be left to a Council or affected populations. A commitment to greater social, economic, and political equity as the foundation to reducing health disparities is in the interest of all Washingtonians.

Assure access to health services

Polling indicates that Washingtonians' greatest health concern is whether or not they can access needed health services. Personal angst and policy debates center on health care costs. Perhaps the greatest attention has been paid to the number of people who lack insurance, but forum participants reminded us that even those who have access to insurance are greatly concerned about rising out-of-pocket costs, increasingly unaffordable premiums, and difficulty getting in to see a provider. The access problem is compounded by health labor shortages. Nursing positions go unfilled in hospitals. Emergency services close due to lack of certain physician specialty coverage. People in rural communities must travel long distances for dental care.

Solving the access crisis is challenging because there are many stakeholders with many perspectives. Payers and purchasers want costs controlled. The usual means to do this is to limit benefits or eligibility, yet patients want any service they perceive is needed. Providers look for sufficient reimbursement with no restrictions on practice. All of these interests detract from the fundamental discussion about what health services should be available and to whom.

Unlike education, health care was not historically recognized as something our state guaranteed to its residents, but there is unspoken sentiment that we should all be able to get it. Washington has taken significant but incremental approaches to ensuring access. For example, it has established a state health insurance program. Now there is interest in guaranteeing that what we pay for is beneficial; that is, evidence-based.

From 1999 to 2003, the Board underwent a process, including review of evidence and public input, to identify a core set of health services that should be available to ensure a healthy state. Called the menu of critical health services, the list provides a basis for the discussion about what health services should be universally accessible (www.sboh.wa.gov/Pubs/documents/2001AccessReport.pdf). As we continue measured steps toward improving health care access for Washingtonians, the menu of critical health services could be used to determine what everyone should receive while we struggle with how to pay and other barriers to access.

Improving access to health services will require state and federal policy changes. In the meantime, local communities have mobilized to identify and fill gaps. Public health agencies work with partners to ensure the availability of services and outreach to vulnerable populations.

Health care for all children is a worthwhile investment for Washington. Robin Arnold-Williams, Secretary of the Department of Social and Health Services, explains on page 20 that this is a priority for

Governor Gregoire's administration. Providing our youth with immunizations, preventive screening, oral health care, and other routine pediatric services ensures a healthy start in life. While not all disease and injury can be prevented, access to good preventive health care for our children is our best opportunity to minimize risks.

Healthy kids have better access to the social and economic benefits of our society. They receive maximum advantage from the educational system and are most likely to grow to be productive adults. Access to health care is the cornerstone to a healthy beginning.

Washington is devoting resources to pay for health care for all of our youth. Public programs are available for those who cannot access private insurance. A sustained commitment and outreach should successfully cover all kids.

Increase quality and contain costs

America spent 16 percent of its gross national product on health care in 2004, according to the federal government. Health care, not housing, is the biggest purchase most of us will make in our lifetime. As a nation, we spent \$1.9 trillion on health care in 2004, or \$6,280 a person. That is a 7.9 percent increase over the previous year's total. But are we buying the right things, are we receiving what we pay for, and are we getting top quality? According to the World Health Organization, the United States ranks first among nearly 200 member nations in per capita health care expenditures, but it ranks 29th in years of healthy life expectancy.

It is not always best to buy the cheapest product. We commonly consider quality when purchasing a car, yet rarely factor quality into medical purchasing. The Institute of Medicine report *To Err Is Human: Building a Safer Health System* found that medical mistakes cause 44,000 to 98,000 deaths each year—more than HIV/AIDS, breast cancer, or vehicle accidents. These medical mistakes are largely attributable to poorly integrated services, poor information services, and other types of system errors. The report estimated the annual costs of preventable errors at \$17 billion to \$27 billion.

Government is the primary funder of health care in the United States, according to the Employee Benefit Research Institute and other sources. A major share of government health expenditures comes from state funds and federal funds administered by states. It is not surprising, therefore, that health care is considered the most critical cost driver for state government.

As Steve Hill, Health Care Authority Administrator, points out in his essay beginning on page 23, health care is projected to consume almost 28 percent of state spending in 2006, compared to 22 percent in 2000. If one includes federal funds appropriated by the state for programs such as Medicaid, the percent of all appropriations that go to provide health insurance, direct care, and public health programs approaches 50 percent.

Steve Hill rightly notes that this trend is unsustainable, and that every new dollar spent on health care means less money available for other government services. Moreover, as health care costs rise, the state will have less money to expand access by covering more of the uninsured and underinsured, particularly children. Worse, it will feel pressured to cut back on current enrollment levels or reduce benefits in programs like the Basic Health Plan and Medicaid. That would mean less access to appropriate care.

As a major purchaser of health care services, Washington State is committed to obtaining value, defined as quality divided by price. Cost containment is only one piece of the health care purchasing puzzle. The state can improve value by improving efficiency in contracting and purchasing and by improving patient safety and overall quality of care.

On page 28, Gary Weeks, director of the Department of Labor and Industries, discusses an example of a state-sponsored effort to control costs and improve quality simultaneously. While on page 11, John Lee, director of the Washington Department of Veterans Affairs discusses ways to improve access and to cut costs to the state by ensuring the veterans in this state take full advantage of any federally funded health care to which they may be entitled.



Working to eliminate health disparities

By Ellen M. Abellera, Executive Director, Commission on Asian Pacific American Affairs

Washington State can become the “healthiest state in the nation” only by eliminating the “health gap” that lowers the quality of life, limits economic advancement, and shortens life expectancies for many subgroups of our population, including people of color.

Washington State held the first Diversity Health Summit to eliminate health disparities for people of color on September 30, 2005. Conference sessions covered a broad range of topics that connected with Governor Gregoire’s health priorities—recognizing the importance of healthy children, exploring prevention and wellness, and looking at ways to better identify and screen for health conditions for minority and ethnic populations of all ages.

In Washington State and nationally, Asians and Pacific Islanders, Blacks, Hispanics and Native Americans suffer more than whites from cancer, diabetes, hepatitis, heart disease, stroke, HIV/AIDS, tuberculosis, and other ailments. Most of these groups live much shorter lives than whites.

The summit was a call to action collaboratively convened by the state’s four ethnic commissions: the Commission on African American Affairs, the Commission on Asian Pacific American Affairs, the Commission on Hispanic American Affairs, and the Governor’s Office of Indian Affairs. Other partners included the Governor’s Office, Department of Health, State Board of Health, Washington Health Foundation, Department of Social and Health Services, Susan G. Komen Breast Cancer Foundation, and HumanLinks Foundation.

The fruits of the summit were “intercultural networks”—work groups that will continue efforts in four areas: providing more health outreach and prevention in communities of color; improving health care access, insurance, and availability in communities of color; addressing behavioral and mental disparities among communities of color; and promoting greater cultural competence in the health care community.

One of Christine Gregoire’s first successes as Governor was extending health insurance coverage to 73,000 additional children—a move that promises to reduce disparities by improving access to care for low-income families, many of whom are people of color. In March, the Governor signed a package of health disparities bills introduced by Senator Rosa Franklin that addressed the diversity of the health care workforce, cultural competency training for health professionals, and tribal government participation on the State Board of Health. They also established the Governor’s Interagency Council on Health Disparities and created a process for evaluating the impact that legislative and budgetary proposals would have on health disparities.

The ethnic commissions are looking forward to working with the State Board of Health and other partner agencies on the council to create a statewide plan for reducing health disparities. We in state government must continue our work to effect awareness and education and create solutions for health disparities, both globally and on the policy level.

Maximizing Veterans' Access and Eligibility

By John Lee, Director, Department of Veterans Affairs

One in nine Washington State residents is a veteran. The 2000 U.S. Census reported more than 670,000 veterans in our state. In addition, more than 60,000 active duty troops work at our military bases and live in our communities. Veterans and their issues cut across all socioeconomic lines and influence our city, county, and state governments' ability to serve all residents.

The injuries and illnesses that veterans endure as a result of their honorable military service can be visible, but are often deep and invisible. Many veterans who served during the Vietnam War are fighting various forms of cancer, hepatitis C, and post traumatic stress disorder (PTSD). Their children may have congenital conditions such as spina bifida, which has a direct correlation to Agent Orange, a jungle defoliant used during the Vietnam War. Other veterans, particularly those deployed to Iraq and Afghanistan, return with conditions influenced by combat exposure, geography and other environmental factors. These veterans and family members are eligible for U.S. Department of Veterans Affairs (VA) health care and monetary compensation in many cases, but many have not accessed their benefits for a variety of reasons.

When veterans apply for and receive VA health care, the resulting costs shift to the federal government, and decrease their reliance on state assistance programs, which frees state resources to care for other needy citizens. VA compensation and pension dollars are typically spent in local communities, generating sales tax revenue for cities, counties and the state. This income also contributes to the economic viability and independence of those who are in receipt of those dollars, and often prevents catastrophic events such as homelessness.

The Department of Social and Health Services (DSHS), in partnership with the Washington Department of Veterans Affairs (WDVA), is identifying hundreds of veterans and spouses in community nursing homes eligible for benefits for which they were previously unaware. This partnership erased lines related to data sharing, health information protection and other obstacles that often prevent agencies from collaborating. As a result, veterans and other family members are receiving health services funding through the VA, Tricare, and other federal programs. Medicaid and other state resources are being reallocated to other critical programs or clients.

WDVA is poised to work with health care and social services providers to ensure every veteran in Washington State has the opportunity to learn about and apply for his or her benefits. The WDVA Service Officer Network has the expertise and access to the VA system to verify eligibility and develop disability, survivor, and other claims. Community providers such as physicians, nurses, counselors, homeless services staff, and state agencies that work with those in need must ask: *"Have you ever served in the military?"* Asking this simple question can begin the process of connecting a needy veteran, widow, or eligible family member to the largest health care network in the nation, and ultimately improving the living conditions of some of our most vulnerable citizens.

WDVA is building capacity to provide veterans benefits information and services to our communities through partners such as DSHS, Employment Security, Office of Superintendent of Public Instruction, Military Department, Department of Health, faith-based, community nonprofits, and veterans service organizations.

Veterans served and continue to serve this country with honor. Conditions and illnesses developed as a result of their service will be addressed by the federal government when our health and social services providers make the connection. Have you ever served in the military?





Better Health through Prevention and Partnerships

By Mary Selecky, Secretary, Department of Health

Governor Gregoire has challenged our state to be healthier. A healthier state will mean a better quality of life and will help slow escalating health care costs. We need to look at the core of health status to best understand how we can improve it. At the direction of the Governor, the Department of Health has convened key state agencies to craft a prevention agenda. The Healthy Washington Workgroup draws input from many partners: Department of Social and Health Services; Health Care Authority; Office of Superintendent of Public Instruction; State Board of Health; Department of Ecology; Department of Transportation; Department of Community, Trade and Economic Development; and Department of Agriculture. The group's agenda embraces prevention in ways that are both timely and bold. Every one of us can be a part of the prevention story.

The Healthy Washington Workgroup is taking a long-range view. The group has set challenging goals that involve changing systems and behaviors that can impact health before birth and all the way through adulthood. In a healthier Washington, babies will be born into families that can support children in ways that are essential for lifelong health. Both ongoing and new work address that goal. The workgroup looks at prevention from a lifestyle perspective, picking up where science suggests it is possible to reduce the rate of chronic disease. The group is focusing on reducing exposure to environmental toxins—especially for children, who are so susceptible to the damaging impacts of these toxins. And for those of us who have health conditions, the prevention workgroup seeks ways to enable health care systems that help us stay as healthy as possible.

The prevention agenda focuses on five goals:

1. Increase the proportion of children and youth who have a medical home.
2. Increase healthy eating and active life opportunities, including employer-focused initiatives.
3. Reduce the use of tobacco, alcohol, and other drugs.
4. Create a coordinated approach to school health so that student health needs are met, and they are ready to learn.
5. Reduce exposure to harmful environmental toxins.

Increase the proportion of children and youth who have a medical home

A medical home isn't a place; it's an approach to providing high quality, comprehensive health care services. It's accomplished through a team of health care professionals, including a primary care provider. A medical home coordinates all services that affect a child's health, including prevention. It includes early childhood health screenings, well child exams, and care coordination. Ideally, it is in the community where the child lives and receives all educational, psychosocial, and health care support.

Improving health by promoting healthy behaviors and assuring environments that promote and protect human health are both State Board of Health priorities.

See essay, page 3.

The focus of Healthy Washington is to increase the percentage of children and youth who have a primary source for health care. Affordable and available health insurance is one of the keys to success. Covering all children is one of the goals of the Gregoire administration (see page 20).

Adults can benefit from a medical home as well. It's clear that managing chronic disease using the medical home approach results in much better health.

Increase healthy eating and active life opportunities—including employer focused initiatives

If the options for living a healthy lifestyle are made easy, it's more likely that people will take advantage of them. Research has shown that behavior choices and subsequent health outcomes are strongly influenced by the culture we live in. Simply put, if people have access to healthy foods, they are more likely to eat healthier. If neighborhoods have sidewalks or accessible walking trails, people are more likely to exercise. The environment we live in directly affects our health. Living with serious chronic disease does not have to be an inevitable part of growing older. Through our own habits and behaviors we can impact the onset and progression of serious health problems such as diabetes or heart disease.

Healthy Washington is addressing the leading causes of preventable illness by promoting both physical activity and nutrition policies that reach into communities where we work, live, play, and go to school.

Eating healthy food and making sure we're physically active every day is something we should all strive for. The Healthy Washington Workgroup is focusing on schools and employer-based initiatives. In 2004, the state passed legislation requiring Washington school districts to develop model school nutrition and physical activity policies for all students. The goal is to have every school adopt policies that allow only foods and beverages that are consistent with national nutrition standards. The law also requires schools to adopt curricula and policies that provide quality physical activity for all students. While many schools across the state are achieving these goals, implementation is far from universal. Healthy Washington believes every school campus in the state should offer healthy choices for nutrition and physical activity.

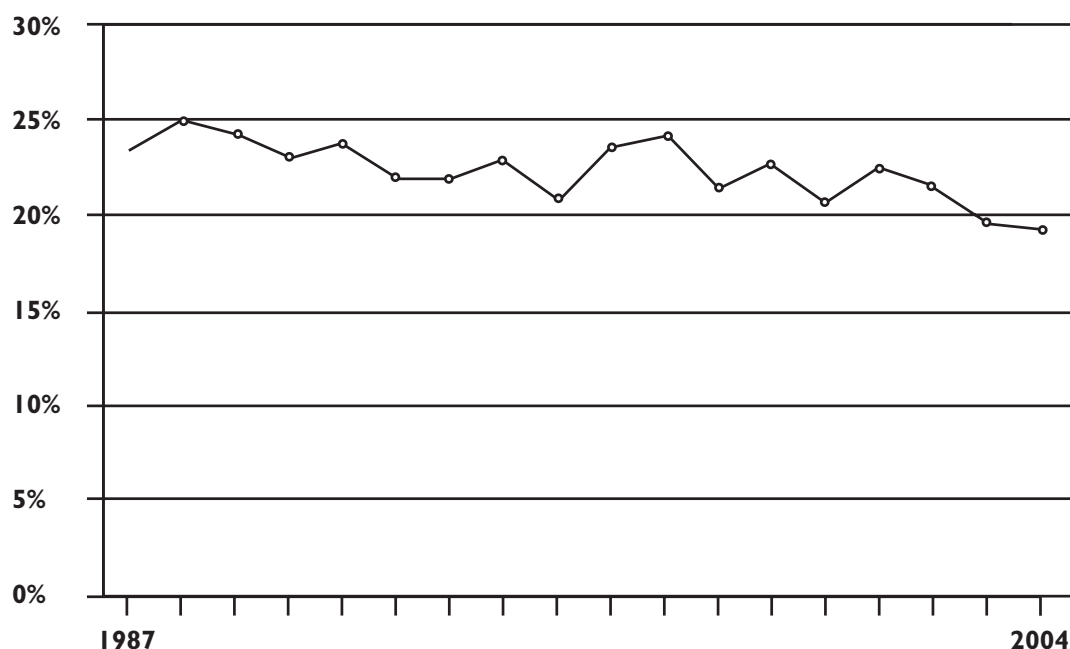
Employers play a central role in this important work to make our state healthier. They often shoulder the growing cost of health insurance. Healthy Washington recommends adoption of employer-based policies that provide benefits and programs to improve employee health. These may include employee health assessments to match health care services to known risks. Or they may involve the use of "personal coaches" to help employees navigate the health care system. Employers might also offer staff prevention benefits, like tobacco cessation or health club memberships. Other ideas involve the workplace itself—developing policies like "walking meetings" and healthy foods in vending machines. Healthy Washington will analyze and promote promising and effective employer-based initiatives aimed at keeping employees healthy.

In addition, the Department of Health and the Health Care Authority are working together on a Governor's initiative for state employee wellness and health promotion. As Washington's largest employer, state government is striving to set an example by encouraging policies and behaviors that promote good health.

Reduce use of tobacco, alcohol and other illicit drugs

The use of tobacco, alcohol and other illicit drugs has a significant impact on the health of people in our state. Tobacco use alone is responsible for the premature deaths of about 8,000 people in Washington annually. Our state's commitment to tobacco prevention and cessation is saving lives and money. Washington is making great strides toward reducing tobacco use and preventing kids from starting this deadly habit. Since the state's Tobacco Prevention and Control Program began six years ago, 65,000 fewer youth smoke. Overall smoking is down 13 percent and Washington has 130,000 fewer smokers. The number of pregnant women who smoke has dropped 25 percent. While this work has made a big impact, there is a lot more to do in the years ahead. Forty-five kids in Washington still start smoking every day. More than 10 percent of babies are born to mothers who smoked during pregnancy. Tobacco prevention and control has

Rate of Tobacco Use Among Adults



Rate of Tobacco Use Among Adults

Description: This indicator is based on self-reported tobacco use on the Behavioral Risk Factor Surveillance System (BRFSS). The measure represents the percent of respondents who answer “No” to “Have you smoked at least 100 cigarettes in your entire life?” or “Not at all” to “Do you now smoke cigarettes every day, some days, or not at all?” The survey is conducted annually by the Washington State Department of Health in conjunction with the U.S. Centers for Disease Control and Prevention (CDC) to gather data on factors affecting the health of Washington residents.

Sources: Department of Health; CDC.

a direct impact on the health of people in Washington. Healthy Washington will continue to place a strong emphasis on this work.

Funds for the tobacco prevention program will drop significantly in fiscal year 2009 when money in the tobacco control fund from the Tobacco Master Settlement Agreement is depleted. Unless the tobacco control fund is replenished, the program will have to be supported through other sources at the local level—meaning that prevention efforts will be inconsistent. Experience from other states has shown that without a fully funded comprehensive program, smoking rates will climb, as will smoking-related health problems.

Each year, prenatal alcohol use results in as many as 1,000 babies born in Washington with birth defects and developmental disabilities. Over the lifetime of a person born with fetal alcohol syndrome disorder, our social service system pays about \$2 million. It’s a devastating condition that is entirely preventable — it simply doesn’t occur when pregnant women don’t drink alcohol.

Reducing fetal alcohol syndrome is one of Healthy Washington’s prevention priorities. Key strategies include increasing chemical dependency treatment for pregnant and parenting women and expanding access to fetal alcohol syndrome resources.

Create a coordinated approach to school health so that students are healthy and ready to learn

Healthy children are better students. When students are sick, distracted, or constantly absent, schools and teachers can't do their job. Learning can take a back seat to other more pressing concerns kids face. If schools don't deal with children's' health by design, they deal with it by default. The Healthy Washington Workgroup wants to increase the state's capacity to manage the important physical and emotional health needs of students.

Research shows the essential parts of school health include quality health and physical education, counseling and support services, good nutrition practices, available health services, involved families, and school staff who model healthy practices. Many of these components affect student learning and can have lifelong health impacts. When students are taught about unintentional injury, violence, suicide, tobacco use, addiction, unintended pregnancy, and nutrition, they're more likely to understand their role in preventing serious health problems. When they eat nutritious food at school and get daily exercise, they are practicing healthy behavior. (See sidebar, page 16, by Valoria Loveland, Director, Department of Agriculture.)

When all the key elements are coordinated, schools see improved behavior, better academic performance, fewer kids smoking, and reduced obesity. Under a federal grant, the Office of Superintendent of Public Instruction has funded a cooperative agreement with the Department of Health to encourage partnership and collaboration between health and education in the state. (See sidebar, page 16, by Superintendent of Public Instruction Terry Bergeson).

Reduce exposure to harmful environmental toxins

There is mounting evidence of the impact of toxins in the environment on childhood development. From the well-known effects of lead to the more recent concerns over mercury and PCBs in fish, it has become clear that children are not "little adults." Per pound they eat more food, drink more water, and breathe more air than adults. The younger the child, the more susceptible they are to the health effects of environmental toxins. They can suffer deficits in learning and behavior from low-level exposures in early life. The developing nervous system is highly sensitive in the womb and remains extremely vulnerable through the teen years.

Healthy Washington is targeting children in an effort to reduce human exposure to environmental toxins. We're working with a variety of partners to address environmental contaminants in places where children congregate such as schools and daycares. The group will continue to work with the Department of Ecology on strategies to reduce exposures to persistent, bioaccumulative toxins (also known as PBTs). This will include continued evaluation of health risks from other contaminants and increased efforts to effectively communicate health risk information to Washington residents. (See sidebar, page 18, by Department of Ecology Director Jay Manning.)

While people often equate health with individual behaviors, there are many factors that determine the health of people in our communities. The environment we live in, access to information and resources, and quality health care are all important elements as we work for a Healthy Washington.



A new framework for addressing student health

By Terry Bergeson, Superintendent of Public Instruction

Too many of our children face economic, social, and health barriers to learning. Drop out and testing data tell us that struggling students are disproportionately ethnic minorities or low-income students. These are the same children that our public health partners tell us are disproportionately impacted by health issues and chronic disease. Health and education are partners. Our collaborative efforts will ultimately strengthen student health and educational success.

Although education's mandate is to provide students with academic skills and knowledge, I recognize the importance of meeting the diverse needs of students. Creating and maintaining a supportive learning environment is a pivotal aspect of successful school improvement efforts. Few students achieve their academic potential if they aren't healthy, safe, and supported at school.

Through federal and state resources, the Office of Superintendent of Public Instruction currently provides some funding and technical assistance for school health services in programs that reach families, services for homeless students, school food programs, safe and supportive learning environments, and many other critical activities that begin to break down some of the social and health barriers to learning. All schools and districts also have programs and staff to implement health and fitness education and maintain safe and clean facilities. Still, there are unmet needs that threaten student health and safety.

Coordinated school health provides the framework to address health within our education system and assist us in preventing kids from falling through the cracks. This framework is a way to talk about the health-related services and activities that promote learning across agencies and systems.

Until recently, few schools or districts have succeeded in fully implementing coordinated school health or quantifying the impact of this coordination on student health and achievement. In Washington State, partnerships between governmental and nongovernmental agencies have resulted in the implementation of the Healthy Schools Leadership Program (HSLP). This program assists schools in implementing the full coordinated school health model. Currently, through a coordinated school health grant funded by the Centers for Disease Control, the Office of Superintendent of Public Instruction and the Department of Health are partnering to offer a second cohort of HSLP.

Coordinated school health is an organizing principle for all of these activities and serves to ensure that there is less duplication of effort. We appreciate our partnership with the State Board of Health to develop a system that operates smoothly and seamlessly for all children.



Students benefit from locally grown foods

By Valoria Loveland, Director, Department of Agriculture

With more than 36,000 farms operating in Washington and some 300 farm products available, students have incredible choices for locally grown foods when it's time to eat. And through our Farm-to-Cafeteria program, kids get that direct connection to local produce.

Farm-to-Cafeteria is a great idea that's paying dividends. Students learn about and enjoy healthy, fresh foods. Our farmers find a new market for their top-quality products. My department's Small Farm & Direct Marketing Program helps create these programs; it connected Washington farmers to 35 public and private school districts last year. (It also helps bring locally grown foods to nursing homes, hospitals, day care centers and others.)

Farm-to-Cafeteria programs take many approaches. Food services can showcase fresh apples, feature salad greens in a daily salad bar, or highlight Washington-grown food at a one-time harvest meal or special event.

The consumer is a real winner. Because everything is local, foods are served at their peak of ripeness. Different foods come to market every season of the year, so there is always some new taste at the table. Customers give food service directors great reviews on variety and quality. And with the focus on fruits and vegetables, the program is also a boon for public health. When school kids eat more healthy foods, they are less likely to develop chronic weight problems, which can have lifelong health consequences.

One example of imagination and innovation happened at Lincoln Elementary School in Olympia. A parent proposed the idea of an Organic Choices Program for school lunches, featuring a salad bar with fruits, vegetables, whole grain breads and protein such as eggs, beans and cottage cheese. The idea really took off. Students and staff love the focus on healthy and delicious fruits and vegetables, and consumption of those foods increased by 27 percent. The program has expanded to 11 elementary schools in the Olympia School District, and other districts have taken notice. The U.S. Department of Agriculture singled out the program as a wonderful example of creativity in school food service. And with local farms providing many of these foods, our state's producers are reaping the benefits, too.

Farm-to-Cafeteria is also a great way to integrate health education and agriculture with the dining experience in the cafeteria. Schools can highlight locally grown foods during mealtimes, kickoff special events with local farm organizations, create nutrition curricula around school gardens, and take field trips to local farms.

Twenty-five schools across the state participate in our Free Fruit and Vegetable program to provide healthy morning or afternoon snacks at no cost to schools or students. And last year, ten participating schools partnered directly with local farms to provide those foods. Local choices include sliced apples, small apples and pears, dried apple slices, cucumbers, fresh asparagus and mixed green salads. Not only do kids eat more fruit and veggies, they also learn about where food comes from. What a concept!

By building connections between farmers and food service buyers, Farm-to-Cafeteria and related programs increase the economic viability of small farms and strengthen Washington's agricultural economy. In these times of continued economic stress on our state's family farms, we will continue to develop relationships that boost the demand for high-quality local products. We're hopeful that by introducing chefs, retailers, food service directors, and consumers to local farm products, we will create a demand that will last a lifetime.

Schools across the state are seeing the benefits of serving fresh local produce. These programs are a great way to enhance agriculture and nutrition, but they are not always easy to get started and keep going. More policy work is needed to maintain the connections already made between schools and farmers, and to assist more schools to develop these relationships. For example, as public entities, schools must be held accountable for how they manage taxpayer dollars. Appropriate financial safeguards are important, but we must make it easier for schools to develop purchasing relationships with farmers.

This spring, a group of state legislators from across the country came here to learn about farm-to-school programs in Washington, and discuss policy issues that can assist with these programs.

More schools are buying into the Farm-to-Cafeteria connection all the time. We have developed a great resource, a 90-page Farm-to-Cafeteria Connections handbook that shows how to start a program, including numerous resources and case studies of successful projects. To get this free handbook, contact Kelli Sanger at (360) 902-2057, or e-mail her at ksanger@agr.wa.gov. The handbook is also on the WSDA Web site at www.agr.wa.gov/Marketing/SmallFarm.

Every school should be interested in participating in a program that improves the quality of the food service, benefits the health of the kids, enhances the curriculum, and gives a boost to local farmers.



Reducing toxins in our air, water and soil

By Jay Manning, Director, Department of Ecology

In 2000, the Department of Ecology (Ecology) released its *Proposed Strategy to Continually Reduce Persistent, Bioaccumulative Toxins (PBTs) in Washington State*.

PBTs are a distinct group of chemicals that threaten the health of people and the environment. They raise special challenges for our society and the environment because:

- PBTs are stable chemicals that remain in the environment for a long time without breaking down (persistent).
- Animals and people accumulate PBTs in their bodies, primarily from the food they eat. As these chemicals move up the food chain, they increase in concentration and linger for generations in people and the environment (bioaccumulative).
- Exposure to PBTs has been linked to a wide range of toxic effects in fish, wildlife and humans, including effects on the nervous system, reproductive and developmental problems, immune-response suppression, cancer, and endocrine disruption (toxic).

PBTs can travel long distances in the environment and generally move easily between air, water and land.

The *PBT Strategy* will guide the continual reduction of risks that PBTs pose to Washington's environment and people. Chemical action plans (CAPs), which are being developed by Ecology in collaboration with the Department of Health and others for specific high-priority chemicals, are the primary means for developing and implementing specific reduction actions and activities.

Ecology recently adopted a rule to guide the development of CAPs (Chapter 173-333 WAC). It is the first rule of its kind in the country; we hope that it will serve as a model for other states to follow.

Mercury was the first chemical addressed under the PBT Strategy. The Mercury CAP describes a process for virtually eliminating the use and release of mercury contamination resulting from human activities in Washington state. It was completed in February 2003 and was co-developed with the Department of Health.

In January 2004, then-Governor Gary Locke asked the departments of Ecology and Health to evaluate flame retardants, also known as PBDEs (polybrominated diphenyl ethers), and recommend ways the state could reduce potential threats from these chemical additives, which are used in everyday household products.

The PBDE CAP, finalized in January 2006, recommends that the Washington State Legislature ban all three of the commonly used forms of PBDEs. While the fire-safety benefits of using flame retardants are clear, a growing body of research indicates that PBDEs are building up in people's bodies, in animals and in the environment. PBDEs have been measured in blood, fat, and breast milk in people around the world. The exact way people are exposed to PBDEs is not fully known, but recent research points to human exposure from air, dust and certain foods.

The three main types of PBDEs used in consumer products (Penta-BDE, Octa-BDE and Deca-BDE) have different uses and different toxicity. In 2001, the total PBDE volume worldwide was estimated at more than 67,000 metric tons, including 56,100 metric tons of Deca-BDE. Manufacturers of Penta- and Octa-BDE in the U.S. agreed to stop producing these two forms at the end of 2004. With the discontinuation of Penta- and Octa-BDE, Deca-BDE will account for 100 percent of PBDE use. Studies indicate that Deca-BDE can break down in the environment to the more toxic and bioaccumulative Penta- and Octa-BDE forms.

While additional research is needed to find a safer, effective and affordable alternative to Deca-BDE, the recommendations in the PBDE CAP were developed after a thorough consideration of what is known and what is not known. For more information, please see the PBDE Chemical Action Plan at www.ecy.wa.gov/biblio/0507048.html.

At the departments of Ecology and Health, we believe it is important that we tackle PBTs in partnership with others, including our fellow state agencies and lawmakers, along with other states, the federal government and even other nations. Both the mercury and PBDE CAPs were developed through a multi-program, multi-agency effort, with external stakeholders involved at each step.

So what's next? Two of Ecology's goals as Washington's principal environmental management agency are to prevent pollution and clean up existing pollution. Along those lines, one of my three current strategic priorities for Ecology is to reduce toxic threats.

In recent years, we have found an increasing trend of toxic substances found in the sediments of Puget Sound, in the fish we eat, and in our homes, offices and bodies. Our toxics strategy has four key components:

1. Improve our understanding of toxic chemicals in sources and products that are a threat, and determine how best to phase them out.
2. Get toxics out of the air we breathe.
3. Get toxics out of our water and soil.
4. Work with businesses to reduce the use and production of hazardous substances.

The PBT efforts are an important part of this priority. We are currently developing, in consultation with the Department of Health, our multi-year schedule to prioritize chemicals for the preparation of chemical action plans. Development of this schedule will follow a process outlined in the PBT rule. The process will include getting input from other agencies, as well as the general public. For the 2007-2009 biennium, we intend to produce two more action plans, but I don't yet know which two will be chosen. We will know once the multi-year schedule is finalized. We do know, however, that we will need additional funding, first to develop the CAPs, and then to implement them. We may also need some additional authority, but I believe that would be rolled in to some subsequent agency legislation.

We are only focusing on chemicals on which we can truly make a difference. For example, as a result of the Mercury Chemical Action Plan, it became illegal to sell or distribute thermometers, manometers (pressure-measuring instruments, such as blood-pressure gauges) and novelty items such as toys, games, or jewelry that contain mercury as of Jan. 1, 2006.

Our PBT rule will guide us in prioritizing future work. And with the continued efforts on the part of Ecology, the Department of Health and other state agencies, as well as external interested parties, we can significantly reduce the risks to the health of our citizens and the environment from exposure to PBTs.



Covering All Children by 2010

By Robin Arnold-Williams, Secretary, Department of Health and Human Services

An overriding theme of Governor Gregoire's health care agenda is our state's commitment to the health of Washington's children. The Governor believes that children's health insurance coverage is essential to the future of our state. When children have access to cost-effective preventive and health care treatment, it is not only an important step toward good health but guarantees they have the capacity to use their education to become productive adults in the 21st century. Having access to health coverage means healthier children; healthier children mean healthier, more productive adults.

National studies have found:

- "Uninsured children have less access to health care, are less likely to have a regular source of primary care, and use medical and dental care less often compared to children who have insurance. Children with gaps in health insurance coverage have more access problems than children with continuous coverage."
- "Previously uninsured children experience significant increases in both access to and more appropriate use of health care services following their enrollment in public health insurance programs."
- "Uninsured children often receive care late in the development of a health problem or may not receive any care. As a result, they are at higher risk for hospitalization for aggravated conditions, late-stage diagnoses, or missed diagnoses of serious and even life-threatening conditions."
- "Undiagnosed and untreated conditions that are amenable to control, cure, or prevention can affect children's functioning and opportunities over the course of their lives. Such conditions include iron deficiency anemia, otitis media, asthma, and attention deficit-hyperactivity disorder."

There also is national recognition that coverage for children, like coverage for our seniors through Medicare, should be a national priority. To this end, Congress both expanded Medicaid children's coverage mandates and optional coverage opportunities. A national commitment was enacted in 1997 when Congress established the State Children's Health Insurance Program (SCHIP), which is a federal/state partnership to make health coverage available for all low-income children.

Washington: Leader in health coverage for children

Washington has long been a national leader in providing health insurance for its children. In 1988, our state implemented the First Steps Program, which provided health coverage and prenatal care to pregnant women and infants in households up to 185 percent of the federal poverty level (\$30,700 per-year for a family of three). This program has led to a

*Providing health
insurance for children
is a key piece
of a broader
State Board of Health
priority—assure access
to health services.
See essay, page 3.*

major reduction in infant mortality and low-birth-weight children in our state. Washington ranks as the third-lowest state in the nation for infant deaths per 1,000 live births (deaths to infants from birth to 364 days of age) and low-birth-weight births per 100 live births (less than 2,500 grams or 5 lbs. 8 oz.), and it is the second-lowest state in the nation for very low-birth-weight births per 100 live births (less than 1,500 grams or 3 lbs. 4 oz.).

In 1991, Washington made available Medicaid coverage to children in families up to 100 percent of poverty (\$16,600 per-year for a family of three). Coverage was also made available to children who were not eligible for Medicaid due to their citizenship status. In 1994, our state expanded Medicaid coverage for children up to 200 percent of poverty (\$33,200 per-year for a family of three). As part of our state's health reform efforts, these children receive coverage through our Healthy Options managed care program, which is designed to provide a medical home to ensure primary and preventive care.

At the time Congress enacted the SCHIP program in 1997, Washington was one of only four states that were already covering children at the national target level of 200 percent poverty. In 2000, we implemented our SCHIP to offer health coverage for children in families up to 250 percent of poverty (\$41,500 per-year for a family of three). Washington's SCHIP is the sixth-highest in coverage levels among states.

To ensure that children have access to seamless and appropriate coverage, Washington's publicly financed children's programs offer the same coverage, which is based on the Medicaid program. Families in the Basic Health Program (BHP) are able to access full-scope coverage for their children without additional out-of-pocket expense through a program we call BHP+. Today, some 27,000 children are enrolled in BHP+.

These efforts have yielded gains in increasing health coverage for children. In 1998, the Washington State Population Survey reported that the uninsured rate for children was 7.8 percent. In 2000, the uninsured rate dropped to 5.5 percent and in 2002 the rate was 4.5 percent.

Due to data limitations, national comparisons are difficult to make. The Census Bureau's Current Population Survey (CPS) shows that in 2003-04 Washington ranked 13th in health insurance coverage for all children and eighth in coverage for low-income children. Vermont has the lowest uninsured rate for children and Texas has the highest rate. Washington is roughly among the top quartile of states in terms of providing coverage to children.

Governor Gregoire's coverage initiatives for children

During the state's recent budget crisis, we were faced with downturns in Washington's economy and continued increases in health expenditure growth rates (9 percent per year) that were three times greater than state revenue growth rates (3 percent per year). Medical assistance reductions in that era included a rollback in BHP coverage from 130,000 to 100,000 slots, reductions in the Medicaid adult dental program, elimination of 12-month continuous eligibility for Medicaid children, and a Medicaid waiver to adopt premiums for Medicaid children in households above 150 percent of the federal poverty level.

We also terminated our Children's Health Program (CHP) for non-citizen children, but attempted to transition this population into the BHP. Initially, some 13,000 children and adults enrolled in BHP by November 2002. Unfortunately, that enrollment dropped to 3,500 by June 2005. In total, the various changes in Medicaid policies that were implemented in April and July 2003 resulted, by October 2004, in 39,000 fewer children receiving state-financed coverage.

Upon taking office in early 2005, the Governor initiated a series of policy changes to reverse those trends. She directed the Department of Social and Health Services (DSHS) to reinstate 12-month continuous eligibility for the Medicaid children's program. She also opposed implementation of premiums for children in households below 200 percent of the federal poverty level. (Premiums for SCHIP children—families between 201 percent and 250 percent of the federal poverty level—were continued at \$15 per month.) These policy changes will provide coverage for an estimated 70,000 additional children during the 2005-07 biennium. The Governor's budget included more than \$140 million in new funding to provide this coverage.

In examining children's uninsured rates, 70 percent of uninsured children were in households below the 250 percent level covered by publicly funded health programs for children. Except for non-citizen children, our state is making affordable health coverage available for the vast majority of low-income children. To address the gap in coverage for non-citizen children, the Governor requested legislation to reinstate CHP. Her biennial budget request included funding to cover up to 8,500 children by the end of the biennium.

The Governor's 2006 legislative agenda continued these commitments. Her budget included additional funding for CHP, as well as legislation to rule out premiums for children in Medical Assistance programs in families up to 200 percent of poverty. The Legislature supported these initiatives by enacting the Governor's request to eliminate premium requirements for children below 200 percent of poverty and added additional CHP funding to cover 14,000 children by October 2006.

Our ability to provide health coverage to all children relies on a government and business partnership. Two-thirds of all insured children receive coverage through their parents' employers or other private insurance. The other one-third of covered children receives coverage through state-financed health care.

To leverage the availability of employer-sponsored coverage, the Governor requested funding for an employer-sponsored insurance (ESI) pilot, which would provide premium assistance for families to enroll their Medicaid eligible family members in their employer's health plan. Premium assistance will be based on a determination that employer coverage is a cost-effective alternative. Medicaid families continue to be eligible for Medicaid coverage that is not offered by their employer. The 2006 Legislature provided funding for a project intended to enroll some 5,000 persons in employer-covered plans over the next several years.

The challenge to achieve coverage for children.

By 2010, it is estimated that publicly financed programs will cover more than 100,000 additional Washington children than at the start of 2004-05 state fiscal year. While underlying conditions in employment and employer-sponsored health coverage for dependents may change, it is estimated that Washington's uninsured rate for children could be below 4 percent, which would be the lowest in the nation.

This coverage level will require employers to continue to offer dependent coverage and for the state to finance a major increase in children's coverage. This will require nearly \$2 billion in increased funding over the five years between 2005 and 2010. To finance this expansion, we need to improve the quality and efficiency of health care in Washington. Collaborative evidence-based purchasing by the Health Care Authority (HCA), Department of Labor & Industries (L&I) and Department of Social and Health Services (DSHS) will be critical in making a more efficient and effective system needed to reduce the growth rate in health expenditures. It will require us to develop better chronic care management for the 5 percent of our populations that account for close to 50 percent of our health care expenditures. It also will require us to create more transparency in our health-care system and adopt better use of health information technology. (See Steve Hill's essay, page 23.)

The challenge will be all the more difficult for BHP and our Medicaid and SCHIP coverage for children because of the reliance on Health Services Account (HSA) funding. Over the past several years, growth in HSA revenue has not kept pace with the growth in HSA expenditures associated with expanded coverage. This year, we had to draw upon the state's general fund. There will be a greater HSA deficit next biennium, and money from other fund sources will be needed to sustain our coverage commitments.

The state also needs to purchase outcome-based health coverage for our children through good primary and preventive care. This past year, we began performance-based contracting with our Healthy Options contractors to improve both immunization rates and frequency of well child screens. DSHS also participates in other programs to improve the quality of health care for children including ABCD, a program to improve access to dental care for children under age 6, and the Children's Preventive Health Care Collaborative, which focuses on improving the delivery of pediatric care. To further the state's efforts in expanding outcome-based care, the Governor has directed the Health Care Authority and our agency to jointly focus on health outcomes by having our Healthy Options, BHP, and Public Employees Benefits Board contractors focus on a common set of prevention strategies for enrolled children and adults.

Meeting these challenges will be an important part of offering health care coverage for all Washington's children.

Cost Containment and Quality

By Steve Hill, Administrator, Health Care Authority



In 1999 the Institute of Medicine (IOM) delivered its landmark report, *To Err is Human*, that concluded that at least 44,000 and as many as 98,000 Americans die each year in hospitals due to preventable medical errors. In 2001, it followed up with *Crossing the Quality Chasm*, a report on our health care system that defined a dramatic gap between the “health care that we now have and the health care that we could have.” Together, these reports sound an alarm that health care needs a significant overhaul.

In *Crossing the Quality Chasm*, IOM puts forth a vision for the health care system built around six “aims” for improvement. These are built around the core need for health care to be safe, effective, patient centered, timely, efficient, and equitable. They suggest a model for moving toward these goals by involving employers, government, and health insurance plans in creating a performance-sensitive market that causes the medical care system to redesign and improve.

Here in Washington, Governor Gregoire wants the people of our state to have accessible, affordable, and quality health care. However, the state has been spending more and more of its revenue on health care. Annual state spending on health care has increased \$1.8 billion since the year 2000, while Medicaid and state employee health care costs have doubled.

In 2000, health care accounted for about 22 percent of state spending. By 2006, it is projected to consume almost 28 percent. This increase in just six years means that in 2006, the state will spend more than \$700 million on health care that could have gone to transportation, education, public safety, or other state priorities. State revenue has grown 3 percent per year while health care spending has grown 9 percent per year. These trends have been ruinous to families, jobs, benefits, and the other priorities of government. These trends are not sustainable.

At the same time, we have a growing access problem that is directly correlated to the cost problem. More and more families, individuals, and employers are being priced out of the health care system. Rising costs are the result of quality and efficiency problems. Defects, wasteful treatments, variability, and inefficiencies in delivery and administration are driving the cost trends. A recent study found that patients get clinically appropriate care only about 55 percent of the time. In a national survey, 135 doctors were asked how they would treat a patient’s particular condition. They came back with 82 different treatments. The same patient, the same condition, with 82 different remedies. This variability is ineffective, expensive, and dangerous. It is not quality. Up to an estimated 30 percent of our health care is spent on overuse, underuse, or inappropriate use of health care.

As health care costs continue to rise, employers and governments can afford to provide health care to fewer people. And as fewer people can afford health care, more of them are forced to wait until they are sick enough to go to the emergency room, which is the most expensive place to get treatment. And because the uninsured can’t afford to pay for that

Assuring access to health services and increasing quality and containing costs are both State Board of Health priorities.
See essay, page 3.

treatment, employers and government eventually absorb those costs in the form of higher health care costs. The access problem and its solution are inextricably tied to the quality and efficiency issues in health care. Governor Gregoire has proposed a five-point strategy for health care: The State simply cannot afford to continue to pour money into health care and hope for costs to eventually decrease. Simultaneously, the Governor has also been very clear that we cannot even consider eliminating insurance coverage for Washington residents as a solution to the cost problem. On the contrary, her goal is to see all children in the state covered by 2010 (see article, page 17).

She has taken a bolder stance and insisted that the state must actively use its purchasing power to influence quality and efficiency improvements in the health care system. As we move toward health care that is safer and less variable, toward health care use based on evidence, we will have more resources available to provide quality care to all of our population.

Governor Gregoire's initiative proposes five key strategies designed to improve quality and efficiency to make health care affordable and accessible. These strategies are outlined below.

Emphasize evidence-based health care

The first strategy is to increase the use of evidence-based medicine in state health care procurements. Evidence-based medicine simply means using the medication or procedure proven to be most effective. Simply stated, it is health care that works and is based on proven practice and scientific research. Our goal is to limit state reimbursement to treatments that work and not to pay for ineffective or harmful treatments.

There are already successful examples of programs that incorporate evidence-based principles. One is the state's preferred drug list. A panel of medical and pharmacy experts created the list, using the best available clinical evidence to determine the most effective and safest drugs for specific conditions. Only when drugs are comparable in effectiveness is the least expensive drug chosen to be on the preferred drug list. The state saved \$25 million during the program's first year by getting several state agencies to purchase drugs on that list.

We want to expand this evidence-based orientation into other ways of delivering care. This allows the system to eliminate costly, ineffective and dated treatments that are unsafe, do not work, or have been replaced with better treatments (even more expensive treatments, if necessary) to get the quality needed. It means looking at research, not television commercials, to find the right treatment options.

At the Health Care Authority, the state will establish the State Health Technology Assessment Program, which will operate in many ways like the Prescription Drug Program. Health technology means medical devices, procedures, equipment, diagnostic tests, and other health care services. The University of Washington and similar entities will accumulate and evaluate the current scientific evidence about effectiveness. A Health Technology Clinical Advisory Committee, consisting of medical and scientific experts from the community (not state government employees) will then review this evidence and make recommendations to the agencies as to whether the various technologies should be covered, not covered, or covered only under guidelines to be established by the advisory committee.

Some would argue that this is another way to "ration" care. Indeed, this is intended to prevent the state from spending money on treatments that don't work, don't improve health, or may be harmful. But it is different in two important aspects: Coverage and reimbursement decisions will be based on the best available medical evidence and recommended by community medical experts, and their decisions will be based on effectiveness, not cost.

We expect to select six to eight health technologies in the first year for evidenced-based review. One example of current evidence-based guidelines is the off-label use of Neurontin, for which the Department of Labor and Industries and Department of Social and Health Services (DSHS) established a joint guideline on use. Another is bariatric surgery. After reviewing bariatric surgery in the state and finding great variability in mortality rates, DSHS established guidelines on who qualified for the surgery and where it could be done. We have seen no deaths and lower costs since establishing these guidelines.

Better manage chronic care

The second initiative has to do with managing the care of our sickest, most expensive beneficiaries. Five percent of the general population generates 50 percent of all health care costs. This “5-50” population changes through time and it includes people with acute situations, such as trauma or cancer, and people with chronic diseases like diabetes and cardiovascular disease who not only require expensive treatments, but who also develop additional, secondary health problems as a result of their primary affliction.

Getting back to evidence-based medicine, we want to be sure state beneficiaries are getting the best, most-effective treatments. An example of leadership in this area is the Department of Health’s diabetes collaborative, which sets uniform guidelines for best practices and most effective treatments.

But there are also tools to help identify people who have the potential for becoming part of that 5 percent. These “predictive modeling” tools can identify people who are on their way to the terrible quality of life and cost implications of diabetes or heart disease, and these individuals can be approached to start getting the treatment that will help keep them from becoming part of that 5 percent. Instead of just focusing on those already sick, we can begin to work with the potentially sick by developing care strategies that involve healthier lifestyles and education about their health. The use of such care and disease management programs can be affected through the state purchasing process, by requiring contracted providers and health plans to develop and utilize programs that identify and provide early treatment to people at risk of becoming part of that “expensive 5 percent.” We can also take steps directly with state beneficiaries, particularly those in the Medicaid fee-for-service plans and the state employee’s self-funded plan, the Uniform Medical Plan.

Create more transparency in the health care system

When buying a car, there are a number of resources to compare cost, efficiency, reliability, and crash test results. To improve the quality and efficiency of the health care system, we need more transparency and information about the quality and efficiency of providers. This will allow us, as patients, to make better choices. But more importantly, it will motivate the care delivery system to work on improving its quality and efficiency.

There are a number of efforts underway to understand and report on quality and efficiency of health care. Several large health plans are demonstrating leadership in this area, while the National Committee on Quality Assurance is reporting on regional and plan performance. A national collaboration, Care Focused Purchasing, is beginning to collect claims data from health plans that support larger employers, and a Puget Sound collaboration, the Puget Sound Health Alliance (PSHA) is planning to do the same for local employers and health plans.

While the amount of activity is healthy, it is also confusing to providers since they are being asked to report under a number of frameworks. This is to be expected, given where we are on the maturity curve of this effort. We do need to simplify and standardize the process, but we also need to push ahead to make quality and efficiency information available. One sign that we are approaching a tipping point occurred recently when the Institute of Medicine issued the first of three reports on Redesigning Health Insurance Performance Measures, Payment and Performance Improvement. The first report focuses on the selection of measures to support quality improvement and on the creation of a common infrastructure to guide and manage these measures.

The state will work with others, particularly the PSHA, to create more transparency in the health system. We will not add to the confusion and burden on health plans and providers by asking for our own reporting. But we will be strong advocates for getting quality and efficiency information on providers first to providers, then plans, then payers, and then patients. The state will also use its procurement and contracting practices to encourage transparency. Our hope is that the care system will learn and improve from this information and that we can tilt our purchasing to the highest quality and most efficient providers.

Make better use of health information technology

The fourth initiative is to improve health information technology. This is the digital age. But 20 years after personal computers appeared on everyone's desk, doctors are still sending handwritten prescriptions to pharmacists. While some fear the potential abuse of electronic medical records, numerous patients who fled New Orleans had to start from scratch with new doctors who couldn't access medical records that were lost or destroyed in the basement of their previous physician.

And the problem isn't just in New Orleans. The transfer of information from primary care to specialists is less-than-optimum due to a lack of commonly accessed data. As a result, tests already conducted by a primary care physician are then ordered by specialists, and the costs go up some more. An estimated 30 percent of all medical testing is unnecessary and occurs simply because of this lack of communication between doctors. Improved sharing of data will improve safety, aid in decision support, and ultimately reduce errors and lower costs.

Again, the amount of activity in this area—in Spokane, in Whatcom County, at Group Health, and at number of multi-specialty clinics—is impressive. There is a legislatively mandated advisory board working on this now with a final report due in December 2006, and we are planning for a limited number of grants to providers (small practices or hospitals) to encourage implementation. In addition, Governor Gregoire will work with the Legislature to create a statewide goal for health information technology. This is another area in which Washington State should be a leader.

Promote prevention, healthy lifestyles, and healthy choices

The final initiative concerns prevention. Our health is greatly influenced by genetics, environment, lifestyle, and medical care. The way we live—fitness, smoking, and substance abuse—has a 51 percent influence in our health. Medical care has a 10 percent influence, yet our spending is 95 percent for medical care and less than 3 percent to increase healthy behavior and mitigate health risk factors.

A July 2005 report by the University of Washington Health Promotion Research Center on employment-based prevention programs made the following observation on the need for health promotion programs: “Our research found that chronic diseases, including heart disease, stroke, cancer, lung disease, and diabetes, are among the leading causes of death and disability in the state—yet employed Washingtonians have high levels of risk behaviors that contribute to chronic disease:

- 20 percent smoke
- 44 percent do not meet guidelines for vigorous exercise
- 60 percent are overweight or obese
- less than half receive age-appropriate colorectal cancer screening.

We need a renewed focus on prevention and wellness, both to improve people's health and to help control the cost of health care. The state, through the Department of Health, has made remarkable progress on some of these areas. Since it started in 2000, the Tobacco Prevention and Control Program has successfully reduced the number of Washington kids smoking by about 65,000—and the number of adults smoking by 130,000. State government will continue broad, population-based programs, curtail teen smoking, encourage vaccinations, and promote health education.

We will also begin a program with state employees to encourage healthy behaviors. Employees will have access to an online health risk appraisal, where they can confidentially fill out information about their lifestyles, habits, and health history, then receive information about how to take responsibility for and improve their health. We will follow the models of other public and private employers to establish a “best practice” employment-based wellness program.

In total, these strategies will make Washington state government a national leader in the way we buy and use health care.

It will reform the state system so it provides high-quality care at lower cost, while at the same time saving money needed to provide more health care. It also can significantly influence the way private sector health care systems operate in our marketplace.

Transforming Washington's Mental Health System

by Kenneth D. Stark, Director, Mental Health Transformation Project, Office of the Governor

In 2002, the President's New Freedom Commission issued a report on the status of mental health services in the nation. Essentially the report stated that mental health services were fragmented and in need of major reforms. The report presented six goals that would "transform" services. The overarching principles of that transformation were recovery, consumer-driven services, personal responsibility, and the hope and opportunity of self-advocacy. In 2005, the Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U. S. Department of Health and Human Services (HHS), issued a competitive grant opportunity to states across the country to implement mental health transformation. Washington State is one of seven grantees.

In October 2005, Governor Gregoire was awarded the five-year grant for Washington State. Since then, we have been involved in an ambitious effort to gather input and create a comprehensive plan. As that plan comes together, some important themes have emerged that have implications for all public and private systems that provide mental health services.

Mental health and physical health should be treated with an understanding that they are part of a whole. People with mental health problems should not be stigmatized, and their disorders should be treated as any health problem. As with any health treatment, the health care professionals' goal should be returning the individual to a fully functioning life, as free from symptoms as possible. The current system, unfortunately, focuses too much on responding to severe symptoms and stabilization, rather than supporting recovery. Also, little attention has been placed on early assessment, intervention, and preventive care.

Multiple systems providing care must coordinate effectively if we hope to advance recovery. Standards of care vary across systems. Effective and coordinated mental health services are rarely available within schools. Too many people with mental illness receive treatment in unlikely settings such as jails and juvenile justice facilities. While a number of public agencies provide mental health services, there is little or no coordination across these agencies, nor consistency in eligibility criteria or services available. When transitions occur—from child to adult, from inpatient hospitalization to outpatient, from school to work—individuals often get lost. The results are exacerbated symptoms and greater costs to the public. Transformation hopes to tackle these and many other difficult system issues.

Recovery is possible. Outcomes from programs focused on consumer-driven models of care are promising. Often recovery involves securing housing, building relationships and support systems, and finding employment; with excellent long-term results. As the transformation process has unfolded, we have been privileged to meet and learn from consumers whose personal experience of recovery is both dramatic and heart warming. Building systems and services that focus on recovery is at the core of the developing comprehensive transformation plan.

In August of this year the Mental Health Transformation Project will unveil the results of our planning process: the Comprehensive Mental Health Plan for Washington State. Please visit our web site at www.MHTransformation.wa.gov.





Improving health care to reduce disability

Gary Weeks, Director, Department of Labor & Industries

A principle goal of the Department of Labor and Industries (L&I) is to have one of the best worker's compensation programs in the country. This is crucial to maintaining a healthy workforce and a favorable business climate. Premiums must be affordable and they must ensure workers appropriately have access to benefits that help them recover.

Preventing injuries in the first place is the best way to accomplish that, and over the past decade, employers and workers have made workplaces safer, resulting in a decline in the number of workplace injuries. When injuries do occur, however, workers need access to high quality, effective treatment so they can recover and return to their jobs as soon as they are medically able to do so. This maintains productivity, preserves the worker's relationship with his or her employer, and benefits the worker's career over the long term.

L&I has routinely relied on research to help improve the workers' compensation system in ways that reduce the human costs and financial impacts of workplace injuries. Over the past decade, we have significantly improved outcomes for workers and lowered costs. Between 1996 and 2003, our medical costs grew at an average of 6.4 percent annually, while the national average for workers' compensation systems increased an average of 9.2 percent annually. In the past couple years, our medical costs have grown less than 6 percent annually. We have also improved outcomes by using evidence-based medicine. A recent example of this can be found in our two prototype Centers of Occupational Health and Education (COHE).

The idea for the centers grew out of L&I-funded research at the University of Washington and L&I's belief that workers recover more quickly when they have access to attending doctors who understand occupational health best practices. Studies show that attending doctors who employ such best practices are better able to manage workplace disability and find ways to aid injured workers with their recovery. Our COHEs provide comprehensive support services, training in best practices, and incentives to attending doctors who are willing to use occupational health best practices in care of injured workers.

In June 2002, L&I launched its first COHE at Valley Medical Center in Renton. This is an innovative partnership with a large medical center that has more than a decade of experience in occupational health care. In June 2003, we opened our second center at St. Luke's Rehabilitation Institute in Spokane. St. Luke's has extensive experience and skill in injury recovery and the use of information technology to share clinical information with providers.

The COHEs are a unique way to increase occupational health care expertise in their communities. Led by occupational health experts who specialize in treatment of workplace illness and injury, they are centralized community resources for health care providers, employers, workers and labor unions to learn more about returning to work and occupational health best practices. This includes increasing awareness about the benefits of rapidly reporting injuries, setting appropriate patient expectations for return to work, and talking with the employer about workplace accommodations that will help the worker transition back to their job quickly.

L&I encourages doctors to participate by offering higher payments linked to quality measures, free medical education, and supportive health services coordinators. Health services coordinators use new technology developed for the COHEs to track high-risk cases and help remove barriers that keep people from returning to work. They also coordinate services for high-risk workers who need more help with their recovery. At the Eastern Washington COHE, providers, employers, workers, and unions have access to an online "dashboard" that lets them know when a patient needs a service or has hit a barrier to recovery.

The Department designed the Centers in collaboration with business, labor and providers, with advice from the University of Washington. One goal was to engage physicians in continuous improvement of health care for workers. Few doctors have training in disability prevention and management because it is not clinical in nature and not typically part of their training.

The COHEs are very popular. More than 450 doctors participate and more are interested in joining. Based on the program's popularity, the 2005 Legislature funded an expansion of the Spokane COHE to include 260 more doctors in Central and Eastern Washington. This expansion will provide service in 13 additional counties beyond the three that began in 2003.

A recent evaluation by the University of Washington showed that many doctors at the Renton COHE were able to substantially reduce disability and get more patients back to work faster. At the same time, workers were highly satisfied with their health care. The 10,000 injured workers treated by participating doctors were 17 percent less likely to miss work due to an on-the-job injury. They also were 65 percent more likely to be working six months after their injury. More importantly, workers treated by participating doctors were 23 percent less likely to be off work after one year. These outcomes are critical in workers' compensation, since research shows that workers who are off work six months or more due to disability have only a small chance of ever returning to employment. After 12 months off work, the chances of returning to work drop to less than 5 percent.

Provider satisfaction also increased. Doctors reported their ability to treat workplace injuries had improved. There was good financial news, too. Average costs per workers' compensation case were \$585 lower for workers who had COHE doctors compared to a group who saw non-COHE providers. Costs for the 10,000 workers were \$6 million less than a comparison group, for a savings of \$560 per claim.

The COHEs also have fostered greater community involvement in health care improvement for injured workers. Both centers have local advisory committees that comprise leaders from business, labor, and providers. Collaboration among these partners helps identify and support health care improvements.

Other improvements also are occurring through the COHEs. Feedback from the provider quality improvement committees has helped L&I identify ways to reduce administrative burden and make better use of information technology.

This summer, L&I and its business and labor advisory committee on health care is reviewing the results from the Spokane COHE. We will learn whether the improvements like those that showed promise in the suburban, manufacturing environment in Renton were similarly effective in rural parts of Eastern Washington. More importantly, as we gain experience with the COHEs, not only can we make further refinements and improvements, we gain crucial knowledge for improving the system statewide.

The Public Speaks

Every five years or so, the State Board of Health holds public forums in different parts of the state to hear what people are saying and thinking about public health and health care. This year it held three forums—April 11 in Spokane, May 9 in Kennewick, and June 13 in Des Moines. There were approximately 130 guests at the forums combined, and together they provided about 15 pages of comments. Those comments are summarized in Appendix A, which also provides information about obtaining the complete notes.

Not surprisingly participants identified a wide range of problems, and offered an equally varied number of suggestions for how to make things better. We heard big-picture, highly ambitious ideas alongside very detailed, pragmatic suggestions. One person, for example, called for reforming the state's tax system, which disproportionately impacts the poor, leaving them with less money to pay for health care and health insurance. Another suggested bringing institutions and individuals together to jointly purchase licenses to on-line peer-reviewed journals. This would help providers to stay current and to practice evidence-based medicine.

Participants repeatedly called for a complete overhaul of the health care system. One argued “our health care system is sick.” Many people said the ideal was universal coverage, and for many of them, the way to get there was through a single-payer system. They pointed to Canada and Japan as models, and noted that this country spends more per capita on health care than any other country, but dozens of countries have better health outcomes. But we also heard numerous suggestions for more modest, incremental improvements to the existing system. Many providers, for example, called for tort reform to bring down the cost of malpractice insurance and to remove the incentives to practice “defensive medicine” by ordering more tests and procedures than necessary.

A large number of the suggestions were already addressed in the public discussion draft of this report—a surprising number, actually, since the report was never intended to be a comprehensive inventory or policy activities—and there was general support for the Board's and the Governor's priorities. There were, however, several populations whose needs participants felt were not adequately addressed.

One of these populations was people with mental illness. We heard repeatedly that the mental health system is overwhelmed and underfunded, disorganized and disconnected, that jails are often the primary entity caring for the mentally ill. Another was the elderly. Participants asked how state government was preparing for the graying of Washington State. Are we prepared for changing demographics, particularly in the area of long-term care? The third population we heard about that was unaddressed was veterans.

Striking—although not surprising—was how quickly people made the connections between the Board's various strategic directions. People talking about school environmental health recognized that public health is underfunded and also saw the need to increase physical activity and improve nutrition in the schools. People concerned about access quickly noted that access means access to preventive services, not just illness care, and people concerned about prevention argued that better prevention could improve quality and lower costs, which in turn could free up resources that would allow the state to provide greater access to state-funded insurance programs.

Overall, we heard a lot of thoughtful comments about too many emergency room visits that are expensive and often do not result in adequate follow-up care, about the need to lower malpractice costs, about language and cultural barriers, about the need to integrate physical health with mental health, about how practitioners should be more proactive in helping their patients address weight problems, about the number of people who defer care because they cannot get insurance or cannot afford the out-of-pocket expenses, about the need for clearer standards and stronger accountability for school environmental health, and much, much more. It would be impossible to touch on everything here, and trying to do so would only prove to be a disservice to the people whose comments were not included. So please review the appendix, if not the forum notes.

One message did come through, however, that bears repeating: There were numerous comments in the three forums about government being disorganized, unresponsive or unaccountable. Several participants talked about agencies working in silos rather than integrating their programs effectively. The Board heard clearly that state government can do a better job, and it should never stop trying to improve that quality of the services it provides to the people of Washington State.

Conclusion

This is the eighth state health report. Reports have appeared every even-numbered year since 1990 (exception 2000). Although the reports varied, each fulfilled its statutory mandate—each outlined “the health priorities of the ensuing biennium.” These reports have been the only consistent effort in Washington state government to articulate a comprehensive vision and strategy for approaching health issues. These reports are also distinctive because of the level of effort made to solicit input from outside state government—most notably through public forums such as those the Board held this year.

There have been other efforts to look at health issues over the years, and right now we appear to be in a period of heightened activity. On June 20, a week after the Board held the last of its public forums, the Joint Select Committee of Public Health Financing met to discuss findings for its final report, which is due in July. Two days later, a little more than a week before this report was due to the Governor, the Blue Ribbon Commission on Health Care Costs and Access met to define the problem it needs to address and to establish a vision. It also worked on criteria it could use to evaluate proposals that will come before it. This group is charged with recommending “a sustainable five-year plan for substantially improving access to affordable health care for all Washington residents” by December.

When the commission asked for information about other health-related initiatives that will be before the Legislature in 2007, its staff developed a list of 21 studies, audits, and reports that will be produced by a host of task forces, special committees, and other groups. The list did not include this report and other activities going on inside the executive branch only, and it did not include initiatives, such as the Governor’s Interagency Council on Health Disparities, whose work will not be ready for next year’s legislative session.

Each of these efforts could prove extremely valuable, but each focuses on a particular policy area, whether it is reforming mental health or spurring development of electronic medical records or finding ways to subsidize small employees looking to purchase health insurance. Only this report suggests strategic directions that cut across all state agencies and addresses both medical care and public health.

In the first essay of this report, Dr. Kim Thorburn has laid out six strategic directions identified by the Board as state-wide priorities. They are: (1) improve the public health system capacity; (2) improve health by promoting healthy behaviors; (3) assure environments that promote and protect human health; (4) reduce health disparities; (5) assure access to health services; (6) increase quality and control costs. The subsequent sections explain more specific initiatives the Governor and executive agencies will be pursuing in the areas of prevention, access to health insurance for children, and controlling costs and improving quality.

Although the Board heard a lot of different (and sometimes contradictory suggestions) at the public forums, there seemed to be broad support for the strategic directions recommended by the Board, and for the Governor’s policy initiatives. The strategic directions provide the framework for the Board’s own five-year strategic plan. They are also meant, as the statute states, to be “used by state health care agency administrators in preparing proposed agency budgets and executive request legislation”—in other words, as a policy roadmap for executive agencies as they look ahead to 2007.

The Board found it extremely rewarding to be able to take the time and listen to the public about health policy concerns and suggestions. It was impressed by the high level of engagement, commitment, and knowledge exhibited by forum participants. It was also pleased to work with an administration that is committed to keeping health on the front burner. This bodes well for the future of public health and health care in Washington State. Together we can create a more just, more efficient, more effective, and more sustainable system of wellness promotion and care.

Appendix A

Summary of State Health Forum Notes

Spokane, Kennewick, and Des Moines

The following is a highly condensed summary of the comments made at three public forums on health issues held across the state in April, May, and June 2006. Complete notes from each forum are available on line at www.sboh.wa.gov and can also be requested by calling the State Board of Health at (360) 236-4110.

PUBLIC HEALTH

Barriers: Public health is a victim of its own success. Past improvement through sanitation and immunization has resulted in public complacency. People do not have a sense of fear about potential loss of public health capacity, do not understand what public health does, or how to access its services. Capacity has been a challenge for 20 years. Staffing levels are too low. TB is example of problem where there were major successes in the past and the problem returned after public health programs were reduced. HIV/AIDS programs are being whittled away because the majority does not think it impacts them. True work of public health is prevention, which is hard to measure. Our culture is reactive—more responsive to addressing disasters, rather than day-to-day prevention. Responses to emerging diseases diminish other public health programs. Public health lacks capacity to address some current challenges like health disparities. Funding is unstable and siloed. Public health cannot tax community for services. Need state support to offset unfunded mandates (e.g., smoking initiative). Not a clear sense of who is in charge on some issues. Health of population is given too low a priority.

Solutions: Prepare public for possible emergencies (pandemic flu). Establish stable funding sources (especially for environmental health at local level). Level playing field so public health can compete with other local programs for funding. Educate public about how to access public health system. Identify who is responsible to address public health problems. Make more efficient use of resources. Provide taxing authority to health districts. Form more public health partnerships with other health organizations and private industry. Educate legislators about needs for public health system. Public health needs to market itself better. Put nurses back in schools. Develop health workforce—perhaps subsidize professional education. Be more aggressive in addressing problems—be more accountable. Listen more to the public. Insurers and providers need to work together and support public health.

PREVENTION

Barriers: Health care records record height and weight but do not calculate body mass index (BMI), so it is not addressed as fundamental risk. The U.S. Preventive Services Task Force recommends BMI screening but there is no system to put it into practice. Plans not addressing prevention enough. Health providers don't recognize other modalities (alternative therapies). When places offer free screening, many low-income people do not participate because there is no follow-up care—early diagnosis is just scary without follow-up care and treatment.

Solutions: Encourage healthy lifestyles. Better health care begins with healthier community infrastructure. Need access to walking and biking in neighborhoods, not just in distant suburbs. Emphasize prevention and education. Provide routine, free health screenings. Get BMI on to health records. Get guidelines to all health care providers about BMI (require training hours using HIV training requirements as model). Develop better coding to implement obesity guidelines. Research effectiveness of obesity interventions. Develop better models to estimate true cost of chronic disease—tie to health care costs. Encourage more self-management of chronic disease and more patient-centered care. Pay providers for education in clinical context. Reimburse for providing medical home. Encourage people to take better care of themselves instead of relying on medicine to fix the problem. Reorient from disease care to prevention. Provide early entry to prenatal care. Integrate health into early learning. Encourage consumption of fruits and vegetables. Get insurers to pay for nutrition products.

ENVIRONMENT

Barriers: Toxic exposure to children in homes, school environment, water, and food a serious problem. Not enough money. Lack of clear standards. Lack of appropriate testing. People with environmental health problems are disregarded or discredited. People who speak up are marginalized (e.g., Good science not always used in decision-making). Not enough training for people in health care positions. Parents not educated about risks. Baseline health data on people in public schools is not collected.

Solutions: Better education for physicians on environmental health issues. Require data system on health problems in schools. Use “precautionary” approach. Need more leadership and more cooperation among agencies. Someone must take action and be accountable. Need to focus on indoor contaminants, mold in industrial settings, and also other environmental toxins. School health guidelines cannot be voluntary, need enforcement, cannot have school districts policing themselves. Risk managers avoid identifying risks.

HEALTH DISPARITIES

Barriers: Disparities based on gender, culture, geography, elders, rural vs. urban are widespread. Access is based on citizen status. Uninsured get lower quality care. Racism contributes to poor care. Not enough diverse health care providers. The WASL could mean fewer people of color becoming providers. Low-income people are isolated with less access to transportation. Lack of preventive care for low-income people. Oral health disparities (race, income)—no restorative care in dental for low-income kids. Language barriers—no interpreters that convey information accurately, that patients can trust. Getting through system is difficult, e.g., language and not knowing whom to talk to. Cultural and educational barriers make care less effective. Evidence-based medicine a problem because one size and color does not fit all—drug effects may vary by ethnic group. Disparities in environmental health are big—the poorest live in unhealthy environments. No funding for poor school districts to fix unhealthy building environments.

Solutions: Standardize and simplify entry into systems of care. Establish standard of care regardless of income. Focus on evidence based care. Insist on accountability. More health care providers culturally recruited and trained. Begin educating children in elementary and middle schools. Cultivate relationships in schools and with health care providers to increase diverse populations in health care fields. Recruit workers from the communities. Identify barriers and use resources from the communities we serve. Implement policy to training medical providers in providing culturally competent care. Use published information on health disparities to create policies. Evaluate how Washington State policies create health disparities. Monitor and evaluate implementation of Governor’s vision for children’s health access. Strengthen mental health system to address disparities in mental health care. Develop policies that support healthy environments for everyone. Subsidize insurance. Address underlying causes, such as poverty. Go to where the people are—create neighborhood clinics, mobile clinics. Work at neighborhood level. Identify and involve key allies in the community.

ACCESS

Barriers: We have employer-based health care system but employers do not have to provide insurance. Not enough people have access to affordable insurance. Insurance too expensive for many businesses. Cost-sharing (co-payments, premiums shares, etc.) discourage insured from seeking care. Difficult to qualify for insurance due to pre-existing conditions, waiting periods, and convoluted rules. Not enough money spent on prevention, wellness, nutrition, oral health. Oral health for kids and seniors does not seem to be a state priority. Too few providers willing to accept Medicaid/Medicare. Malpractice insurance costs cause doctors to retire or leave the state. Jails often first point of contact for mentally ill. Mentally ill jailed without medications. Mentally ill housed in hospitals because no room in mental health facilities. Number of mental health providers is limited. System is too bureaucratic. Most vulnerable folks can not negotiate complex system, so they go to jail or the emergency room to get care.

Solutions: Universal coverage needed as first priority to fix other things. Single-payer. Allow more people into existing state programs. Address underlying socio-economic issues. Strengthen the safety net. Do more outreach so eligible kids enroll in existing programs. Pay providers adequately. Insist providers see their fair share of Medicaid and Medicare clients. Tort reform. Develop health advocates, especially for mental health. Create more programs for mental health so people are able to leave hospitals/jails when ready. Make dental care more of a priority. Co-locate

mental health services with physical health care services. Provide integrated health care (mind and body). Increase mental health funding and decrease mental health bureaucracy. Blue Ribbon Commission needs to address access. Deliver care “where the patients are.” Have public health nurses on the streets along with social workers. Establish school-based clinics and fund more school nurses. Increase competition between health care plans. Statewide employer and individual insurance mandates. Expand “Project Access” model. Coordinate services when patients make contact anywhere—“no wrong door.” Spend money more wisely—enough money in the system to provide access.

COST AND QUALITY

Barriers: No common definition of “quality.” Consider the Japanese system—money does not buy quality. Providers do not have time to provide quality care and educate patients—not seeing the whole person. Consumers are not health literate. Little teamwork among providers. Insurable people pass on insurance. Salaries and profit of insurance companies are too high. Increasing number of people using emergency room for routine health care, which is expensive and there is inadequate follow-up. Cost increases are associated with preventable disease. Itemized health care bills can not be challenged by consumers since they are not purchasers. Malpractice insurance costs passed on to consumer. Defensive medicine, health care professionals, media, Internet, marketing, and worried-well drive unnecessary (sometimes dangerous) consumption.

Solutions: Create incentive for extra care, e.g. immunizations, in health care practices. Tackle long-term care costs to system. Control malpractice costs. Shift from disease treatment to prevention. Train and use more hospitalists. Better utilize mid-level professionals (auxiliaries), especially those that return to their communities to practice. Only “not for profits” should provide health care. Make sure insurance benefits are better aligned with disease management programs. Insurance companies need to come up with “creative options” such as catastrophic insurance, medical accounts. Working poor need reasonable medical insurance options. Control state mandates that increase costs. Keep emergency rooms from being used as primary care center by remove barriers to access. Build in referral, outreach, and follow-up services using electronic medical records—eliminate redundant services/tests. Decide as society what we value and what to spend money on. Increase transparency of costs and outcomes—post price lists. Re-engage consumers. Look for ways to reduce administrative costs. Ban uncompensated care for non-citizens. Get rid of the bad doctors/health care providers.

About the Board

Mission

The Board's mission is to provide statewide leadership in advancing policies that protect and improve the public's health. It does this by:

- reviewing and monitoring the health status of all people in Washington;
- analyzing policies, providing guidance, and developing rules;
- promoting system partnerships; and
- encouraging public engagement in the public health system.

For more information, visit the Board's Web site at www.sboh.wa.gov.

Membership

Consumers

Keith Higman is the environmental health director for Island County Health Department and has worked in the field of environmental health for more than 11 years.

Mel Tonasket served on the Colville Confederated Tribal Council for 19 years and was formerly chairman of the School Board for Paschal Sherman Indian School in Omak.

Elected City Officials

The Honorable David R. Crump, PhD, a child psychologist, is a Liberty Lake City Council member and a member of the Spokane Regional Health District Board of Health.

Elected County Officials

The Honorable Mike Shelton, Vice Chair, has served as Island County Commissioner since 1993 and, as a commissioner, has also served as a member of the Island County Board of Health.

Department of Health

Mary Selecky is secretary of the Washington State Department of Health and former administrator of Northeast Tri-County Health District.

Health and Sanitation

Charles R. Chu, DPM, a practicing podiatrist, is president of the Washington State Podiatry Independent Physician Association.

Ed Gray, MD, is health officer for the Northeast Tri-County Health District and a member of the Basic Health Plan Advisory Committee.

Frankie T. Manning, RN, MPH, is the associate director of nursing services at the Department of Veterans Affairs Puget Sound Health Care System.

Karen VanDusen, RS, MSPH, is the director of environmental health and safety at the University of Washington.

Local Health Officers

Kim Marie Thorburn, MD, MPH, Chair, is Spokane County's health officer and has directed the Spokane Regional Health District since 1997.

Staff

Craig McLaughlin, MJ, Executive Director

Desiree Robinson, Executive Assistant

Heather Boe, Communications Consultant

Ned Therien, RS, MPH, Health Policy Advisor

Tara Wolff, MPH, Health Policy Advisor

PUBLIC HEALTH
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